Montgomery County 2006 Group Insurance Election Form - Cobra, Temps, Munis

PLEASE DO NOT FOLD OR STAPLE THIS FORM

MARKING INSTRUCTIONS

- Use a No. 2 pencil only.
- Do not use ink, ballpoint, or felt tip pens.
- Make solid marks that fill the response completely.
- Erase cleanly any marks you wish to change.
- Make no stray marks on this form.

CORRECT: ● INCORRECT: ✓ ✗ ◒ ◔

STATUS

- ○ Cobra
- ○ Temp
- ○ Munis

Your Social Security Number

0	0	0	0	0	0	0	0	0
1	1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2	2
3	3	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4	4
5	5	5	5	5	5	5	5	5
6	6	6	6	6	6	6	6	6
7	7	7	7	7	7	7	7	7
8	8	8	8	8	8	8	8	8
9	9	9	9	9	9	9	9	9

Name:
Address:

OHR ID No.

Part A YOUR CURRENT BENEFITS

This will be your default coverage for **2006**.

	MEDICAL	PRESCRIPTION (Rx)	DENTAL	VISION
Plan				
Coverage Level				

YOUR 2006 BENEFITS PLAN ELECTIONS:

For your Medical, Rx, Dental, and Vision elections, your coverage level will be determined by the number of dependents you enroll under the **"2006 Dependent Coverage Elections"** section in **Part F**.

IF YOU WANT TO MAINTAIN YOUR CURRENT BENEFITS AND ARE MAKING NO CHANGES TO BENEFIT PLANS OR DEPENDENT COVERAGE ELECTIONS FOR 2006, THEN YOU DO NOT HAVE TO RETURN THIS FORM.

Part B MEDICAL (Choose one)

- ○ Maintain Current Medical (incl. maintaining Indemnity Plan)
- ○ No Medical Plan
- ○ Kaiser HMO (Includes Kaiser Rx)
- ○ Optimum Choice HMO (Medical Only)
- ○ Carefirst POS High Option (Medical only)
- ○ Carefirst POS Standard Option (Medical Only)

For eligible participants living outside the POS service:

- ○ Carefirst POS High Option - Out of Area (Medical Only)
- ○ Carefirst POS Standard Option - Out of Area (Medical Only)

Part C PRESCRIPTION (Rx) (Choose one)

(Note: Stand-alone Rx coverage not available to Indemnity Plan participants; Kaiser includes Rx coverage)

- ○ Maintain Current Prescription Coverage
- ○ No Caremark Prescription Coverage
- ○ Caremark High Option $4/$8
- ○ Caremark Standard Option $10/$20/$35

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DO NOT MARK IN THIS AREA

Part D DENTAL PLAN (Choose one)

- ◯ Maintain Current Dental Coverage
- ◯ No Dental Coverage (Two year waiting period to re-enroll)
- ◯ Dental PPO (Traditional Dental Plan)
- ◯ Dental DHMO

Part E VISION PLAN (Choose one)

- ◯ Vision Plan
- ◯ No Vision Coverage (Two year waiting period to re-enroll)

Part F 2006 DEPENDENT COVERAGE ELECTIONS - DO NOT ADD OR DELETE DEPENDENTS ON THIS FORM

For each dependent listed below, choose the plans under which you want them to be covered. The number of dependents you cover under each plan will determine your coverage level, i.e, Self, Self + 1, Family, and your cost for that plan. To enroll a dependent in a plan, you must have elected the coverage for yourself above. **If you wish to add an eligible dependent or delete an ineligible dependent, you must complete a dependent Addition / Deletion form and submit it to OHR along with the required documentation and this election form.**

	MEDICAL		PRESCRIPTION (Rx)		DENTAL		VISION	
	Current	2006	Current	2006	Current	2006	Current	2006
1-		Y N		Y N		Y N		Y N
2-		Y N		Y N		Y N		Y N
3-		Y N		Y N		Y N		Y N
4-		Y N		Y N		Y N		Y N
5-		Y N		Y N		Y N		Y N
6-		Y N		Y N		Y N		Y N
7-		Y N		Y N		Y N		Y N
8-		Y N		Y N		Y N		Y N
9-		Y N		Y N		Y N		Y N
10-		Y N		Y N		Y N		Y N

Do not add or delete dependents on this form.

Part G SIGNATURE (Must be signed for elections to become effective)

I have read the materials for the County's group insurance program, as well as the information available on the individual benefit plans. This election form indicates my benefit elections and dependent coverage for calendar year 2006. I understand that I am responsible for my share of the costs associated with these benefit elections. If I have elected no coverage for medical, prescription, dental, and vision, I understand that it is important that I have such coverage elsewhere that is adequate to meet my needs and the needs of my dependents. I understand that these elections are in effect for the entire 2006 calendar year and can only be changed during the year if I have a Change in Status, as described in the Summary Plan Description for the group insurance program. I authorize the release of information contained on this election form to entities such as benefit carriers, to the extent necessary to properly administer the benefits I have elected. I understand that electing benefits to which I, my dependents, or any other person are not entitled is considered fraud. In all cases, I am responsible for my benefit elections and those of other persons for whom I elect to be covered. I further understand that if I willfully misrepresent my eligibility or that of any other person on this election form, or fail to take the steps necessary to remove ineligible dependents, or in any way obtain benefits to which I am not entitled, my benefits will be cancelled, I may be required to repay any claims which have been paid inappropriately, and I may face charges. I understand that the County expects to continue the group insurance program, but it is the County's position that there is no implied contract between participants and the County to do so. I also understand that the County reserves the right at any time and for any lawful reason to amend the program, subject to the County's collective bargaining agreements, where applicable. Further, I understand that the program may also be amended by the County at any time, either prospectively or retroactively, to conform with the Internal Revenue Code.

Signature: _____ **Date:** _____

All forms must be signed and received in the Office of Human Resources, EOB 7th floor, 101 Monroe Street, Rockville, MD 20850, no later than **5:00 p.m., Monday, November 14, 2005.**